Respirator Clearance
Health History Questionnaire

Part A. Section 1. (please print).

1. Date_____ Dept/Organization_____
2. Last Name_____ First Name_____ MI_____
3. DOB: ____/____/_____ Your age (to nearest year)_____
4. Gender: Male Female
5. Your Height: _____ ft. _____in.
6. Your Weight:_____lbs.
7. Your Job Title:_____
8. Phone number where you can be reached by a health care professional who reviews this questionnaire (____)_____
9. Has your employer told you how to contact the health care professional who will review this questionnaire? Yes No
10. Check the type of respirator you will use (you can check more than one category):

    ____ N, R, or P disposable respirator (filter-mask, non-cartridge type only)
    ____Other type (half or full facepiece, powered air purifying, supplied-air, self-contained breathing apparatus)
    ____ Not applicable

11. Have you worn a respirator? Yes No If yes, what type(s):_____

Part A. Section 2.

1. ___Yes ___No **Do you currently smoke tobacco or have you smoked tobacco in the last month?**

2. Have you ever had any of the following conditions?

___Yes ___No a. Seizures (fits)
___Yes ___No b. Diabetes (sugar disease)
___Yes ___No c. Allergic Reactions that interfere w/breathing:
___Yes ___No d. Claustrophobia (fear of closed in spaces)
___Yes ___No e. Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems?

___Yes ___No a. Asbestosis
___Yes ___No b. Asthma
___Yes ___No c. Chronic bronchitis
___Yes ___No d. Emphysema
___Yes ___No e. Pneumonia
___Yes ___No f. Tuberculosis
___Yes ___No g. Silicosis
___Yes ___No h. Pneumothorax (collapsed lung)
___Yes ___No i. Lung cancer
___Yes ___No j. Broken ribs
___Yes ___No k. Any chest injuries or surgeries
___Yes ___No l. Other lung problems you've been told about

Part A. Section 2. (cont)

4. Do you <u>currently</u> have any of the following symptoms of pulmonary or lung illness?

___Yes ___No a. Shortness of breath
___Yes ___No b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline
___Yes ___No c. Shortness of breath when walking with other people at an ordinary pace on level ground
___Yes ___No d. Have to stop for breath when walking at your own pace on level ground
___Yes ___No e. Shortness of breath when washing or dressing yourself
___Yes ___No f. Shortness of breath that interferes with your job
___Yes ___No g. Coughing that produces phlegm (thick sputum)
___Yes ___No h. Coughing that wakes you early in the morning
___Yes ___No i. Coughing that occurs mostly when you are lying down
___Yes ___No j. Coughing up blood in the last month
___Yes ___No k. Wheezing
___Yes ___No l. Wheezing that interferes with your job
___Yes ___No m.Chest pain when you breathe deeply
___Yes ___No n. Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems?

___Yes ___No a. Heart attack
___Yes ___No b. Stroke
___Yes ___No c. Angina
___Yes ___No d. Heart failure
___Yes ___No e. Swelling in your legs or feet (not caused by walking
___Yes ___No f. Heart arrhythmia (irregular heart beat)
___Yes ___No g. High blood pressure
___Yes ___No h. Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart symptoms?

___Yes ___No a. Frequent pain or tightness in your chest
___Yes ___No b. Pain or tightness in your chest during physical activity
___Yes ___No c. Pain or tightness in your chest that interferes with your job
___Yes ___No d. In the past two years, have you noticed your heart skipping or missing a beat
___Yes ___No e. Heartburn or indigestion that is not related to eating
___Yes ___No f. Any other symptoms that you may think are related to heart or circulation problems

7. Do you <u>currently</u> take medication for any of the following problems?

___Yes ___No a. Breathing or lung problems
___Yes ___No b. Heart trouble
___Yes ___No c. Blood pressure
___Yes ___No d. Seizures (fits)

8. If you've used a respirator, have you ever had any of the following problems? (check this question if you've never worn a respirator and move to question 9) _____

___Yes ___No a. Eye irritation
___Yes ___No b. Skin allergies or rashes
___Yes ___No c. Anxiety
___Yes ___No d. General weakness or fatigue
___Yes ___No e. Any other problem that interferes with your use of a respirator

9. Would you like to talk to the health care professional who will review this questionnaire about your answers?

___Yes ___No

10. Have you ever lost vision in either eye? (temporarily or permanently)
___Yes ___No

11. Do you <u>currently</u> have any of the following vision problems?
___Yes ___No a. Wear contact lenses
___Yes ___No b. Wear glasses
___Yes ___No c. Color blind
___Yes ___No d. Any other eye or vision problem

12. Have you ever had an injury to your ears, including a broken ear drum?
___Yes ___No

13. Do you <u>currently</u> have any of the following hearing problems?
___Yes ___No a. Difficulty hearing
___Yes ___No b. Wear a hearing aid
___Yes ___No c. Any other hearing or ear problem

14. Have you ever had a back injury?
___Yes ___No

15. Do you <u>currently</u> have any of the following musculoskeletal problems?
___Yes ___No a. Weakness in any of your arms, hands, legs, or feet
___Yes ___No b. Back pain
___Yes ___No c. Difficulty fully moving your arms or legs
___Yes ___No d. Pain or stiffness when you lean forward or backward at the waist
___Yes ___No e. Difficulty fully moving your head up or down
___Yes ___No f. Difficulty fully moving your head side to side
___Yes ___No g. Difficulty bending at the knees
___Yes ___No h. Difficulty squatting to the ground
___Yes ___No i. Climbing a flight of stairs or a ladder carrying more than 25 pounds
___Yes ___No j. Any other muscle or skeletal problem that interferes with using a respirator

Part B. Other Questions

1. **Have you had any change in your medical status since your last physical examination?**

___Yes ___No

If Yes, please explain:_____

2. **Do you currently wear a respirator?**

___Yes ___No

If Yes, how often? (i.e. 20% of your shift, 1 hour a week, etc._____

3. **Do you experience any health problems when you wear a respirator?**

___Yes ___No

If Yes, please explain:_____

4. **Based on your health status, do you have any questions or concerns about wearing a respirator?**

___Yes ___No

If Yes, please explain:_____

5. **Have you ever been in the military?**
___Yes ___No

If Yes, were you exposed to biological or chemical agents during training or combat?_____

_____

I understand that all information provided in this questionnaire is retained in my confidential medical record. I certify that I have answered the above questions to the best of my abilities. I understand that only information related to my ability to perform the essential functions of my position would ever be released to my employer. All other information is part of my medical record and used for purposes of improving my overall health.

_____	_____
Your Signature	Provider Signature
_____	_____
Printed	Printed
_____	_____
Date	Date